12 53 p.m.

08-20-2015

If continuation sheet 1 of 1

Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED TN2602 B. WING 07/29/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **GOLDEN LIVINGCENTER - MOUNTAIN VIEW** 1360 BYPASS ROAD WINCHESTER, TN 37398 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000' Initial Comments N 000 A licensure survey and complaint investigation #34686 and #35388 were completed at Golden Living Center-Mountain View, on 7/27-29/15. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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